

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003497	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2011
NAME OF PROVIDER OR SUPPLIER CARMEL AMBULATORY SURGERY CENTER LLC, THI			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 003497</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey - ASC full survey June 20-21, 2011</p> <p>Date of ISDH off site review - February 5, 2013</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the June 20-21, 2011, AAAHC Accreditation Survey Report, it has been determined that Carmel Ambulatory Surgery Center meets the requirements for ASC Licensure in Indiana.</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1